CITY OF HOUSTON, BENEFITS DIVISION, P.O. BOX 248, Houston, TX 77001-0248

Municipal Retirement Incentive Option Benefits Election Form

FOR BENEFITS DIVISION USE ONLY				
Department:	Retirement Date:	Medical Effective Date:	Vision Effective Date:	Dental Effective Date:

PRINT OR TYPE WITH BLUE OR BLACK INK ONLY

Employee I.D. Number	Pension System			Social Security No.	Sex	
	☐ Municipal	☐ Fire	☐ Police		☐ Male	☐ Female

Last Name	First Name	M.I.	(Area Code) Phone

Address (Check box if address change) ☐	Apt No.	City	State	Zip Code

A. Group Benefits Choice

Note: The City's five (5) Medicare plans are available to retirees/dependents who are Medicare eligible and covered under Medicare Parts A & B. The CIGNA plans are not available to Medicare-eligible retirees and their Medicare-eligible dependents.

Medical Plan (select one):

- ☐ Cigna Limited Network Plan
  Cigna KelseyCare
  Renaissance
  Memorial Hermann

(Provide a Primary Care Physician number in Section C)

- ☐ Cigna Open Access
- ☐ Consumer Driven Health Plan
- ☐ Retirees of Texas Option Plus

Medical Coverage Type:

- ☐ Retiree/Survivor Only
- ☐ Retiree + Spouse
- ☐ Retiree/Survivor + Child(ren)
- ☐ Retiree + Spouse and Child(ren)

Vision Coverage Type:

- ☐ Retiree/Survivor Only
- ☐ Retiree + Spouse
- ☐ Retiree/Survivor + Child(ren)
- ☐ Retiree + Spouse and Child(ren)

☐ **I OPT OUT OF VISION.** I understand that I may re-enroll in the future.

☐ **I OPT OUT OF MEDICAL COVERAGE.** I understand that I may re-enroll in the future.

Dental Plan - Policy #709643 (select one):

- ☐ DPPO - PVRC - 0001
- ☐ DHMO Plan - PVRC - 0003

Dental Coverage Type:

- ☐ Retiree/Survivor Only
- ☐ Retiree/Survivor + 1 Dependent
- ☐ Retiree/Survivor + 2 or More Dependents

☐ **I OPT OUT OF DENTAL COVERAGE.** I understand that I may re-enroll in the future.

B. Complete the following on yourself and your eligible dependent(s)

Person (Circle One)	Male √	Female √	Medical (Add/Drop)	Vision (Add/Drop)	Dental (Add/Drop)	Last Name, First, M.I.	Social Security Number	Date of Birth
Retiree/Survivor								
Husband/Wife								
Child/Stepchild/Grandchild								
Child/Stepchild/Grandchild								
Child/Stepchild/Grandchild								

C. Complete this section to show your Cigma KelseyCare ID of #8877698010, or Renaissance, or Mayor Healthcare Group Primary Care Physician (PCP) and DHMO Dentist ID numbers, as required for person(s) in Section B.

Person (Circle One)	Male √	Female √	Last Name, First, M.I.	Primary Care Physician No.	DHMO Dentist ID#
Retiree/Survivor					
Husband/Wife					
Child/Stepchild/Grandchild					
Child/Stepchild/Grandchild					
Child/Stepchild/Grandchild					

NOTE: An Eligible Dependent means your legal spouse and any child (natural, adopted, foster, grandchild, stepchild; and a child for whom you are legal guardian and/or have legal support obligation) who is your dependent for federal income tax purposes, resides with you (except in the case of a court order), and is under 26. A dependent may be your child who is 26 or older, primarily supported by you, and incapable of self-sustaining employment by reason of mental incapacity, physical disability or handicap which arose while the child was covered as a dependent under these plans, or while covered as a dependent under prior City plans without a break coverage. Proof of the child's condition and dependence must be submitted within 31 days after the child ceases to qualify.

Relationship documents: Certified Marriage Certificate, Registration and Declaration of an Informal Marriage Certificate (common law), legal and court order documents, and official birth certificates or birth fact.

I authorize any medical, vision or dental provider of facility to disclose to the plan administrator medical, vision of dental information relating to individuals specified on this application.

B. Complete the following on yourself and your eligible dependent(s)

- ☐ Check this box if you and/or your dependents **use tobacco** products. You are not eligible for the monthly voluntary disease prevention discount of $25.00. If all covered persons stop using tobaco products for 60 consecutive days, you may apply for the voluntary disease prevention discount withing the next 31 days. When you apply for the discount, you must not have any covered tobacco product users.
- ☐ Check this box if you and/or your dependents **do not use tobacco** products. You qualify for the voluntary disease prevention discount of $25.00 monthly.

B. Complete the following on yourself and your eligible dependent(s)

I am a retiree or survivor of the City of Houston, eligible to participate in the medical, vision and dental programs. I apply to make the above coverage election and understand that information I have provided is part of my application. All statements made by me may be relied upon by the City; if any information that I have provided is found to be materially incorrect, my coverage may be denied. I realized that coverage my dependents are eligible for at this time, in which I do not enroll them, may not be available until the next open enrollment, unless I provide proof of a change in family status within 31 days of the family status change. I agree that if I have listed ineligible dependents, I may incur a monetary penalty and/or my medical, vision and dental coverage may be canceled. I authorize the pension system to deduct from my pension check my portion of the contribution as it becomes due.

I understand that I must notify the City of Houston when I have an ineligible dependent and that I may not receive a refund of contributions paid for an ineligible dependent. I will be responsible for medical, vision or dental claims paid on an ineligible dependent. All plan provisions will apply to my dependents.

Date:	Contact Phone No.	Signature: